U.S. Department of Labor

Office of Administrative Law Judges
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

(856) 486-3800
(856) 486-3806 (FAX)

Issue Date: 06 April 2007

Case No.: 2005-BLA-05442

In the Matter of

J. B.
Claimant

v.

U. S. STEEL MING COMPANY, LLC
Employer/Self-Insured

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On January 6, 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing (DX 24).[1] Subsequently, on May 4, 2006, the case was assigned to me. In a letter dated July 13, 2006, the Claimant requested a Decision and Order on the evidence of record. No objection was raised, either by the Employer or the Director. Therefore, on August

[1] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits.

15, 2006, I granted the Claimant's request for a decision on the record. The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.[2]

I. ISSUES

The following issues are presented for adjudication:

(1) whether the Claimant suffers from pneumoconiosis;
(2) whether his pneumoconiosis, if any, arose from coal mine employment;
(3) whether the Claimant is totally disabled;
(4) whether the Claimant's total disability, if any, is due to pneumoconiosis; and
(5) whether the Claimant has established a mistake in determination of fact or change in a condition of entitlement pursuant to § 725.310.

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on October 1, 2003 (DX 2). On June 7, 2004, the District Director issued a proposed Decision and Order denying benefits to the Claimant, after finding that the Claimant did not meet any of the elements of entitlement (DX 15). In a letter issued September 13, 2004, the Director confirmed that it received a letter dated September 1, 2004 from the Claimant, which it construed as a request for modification (DX 18). On October 13, 2004, the Director issued its proposed Decision and Order denying the Claimant's request for modification, as "[n]o additional evidence was submitted for consideration [and] [t]herefore the previous decision that [the Claimant] cannot be found entitled to benefits remains unchanged" (DX 19).

In a letter dated October 13, 2004, an attorney representing the Claimant requested a formal hearing (DX 20). A hearing was held before Administrative Law Judge ("ALJ") Alice M. Craft on May 24, 2005. At the hearing, ALJ Craft stated that she had received a request for a continuance from the Claimant, on account of the fact that his counsel withdrew from representation; ALJ Craft granted the continuance.

Thereafter, the matter was assigned to ALJ Paul H. Teitler, and a hearing was held on February 14, 2006. The Claimant did not appear at the hearing, and on February 23, 2006, ALJ Teitler issued an order to show cause why his claim should not be dismissed. In a letter dated March 3, 2006, the Claimant requested "about a 6 month delay," as he had "been sick" and was "getting additional medicals." The Claimant specifically requested that his case not be dismissed. On March 8, 2006, ALJ Teitler issued an Order of Continuance, in which he advised the Claimant that no further continuances would be granted.

Thereafter, the matter was assigned to me, and a hearing was scheduled for September 27, 2006. In a letter dated July 13, 2006, the Claimant requested a decision and order on the evidence of record. Neither the Employer nor the Director objected to this request. Accordingly,

[2] My August 15, 2006 order permitted the parties to submit briefs within 45 days. The Employer submitted a brief on September 26, 2006. The Claimant did not submit a brief.

on August 15, 2006, I granted the Claimant's request for a decision on the record, and cancelled the scheduled hearing.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant was born in July of 1946. He has no dependents (DX 2). The Claimant worked in coal production for at least 27 years (DX 24), and held positions, such as rockman helper, shuttle car operator, general inside laborer, and faceman (DX 3-7). The Employer did not contest the Claimant's length of coal mine employment.

B. Relevant Medical Evidence

The Employer presented two chest X-ray interpretations performed by Dr. Jerome Wiot, as well as Dr. Wiot's curriculum vitae (EX 1, 2, 5). Also, at the request of the Employer, Dr. Allan R. Goldstein performed an evaluation of the Claimant, and submitted a written report and his curriculum vitae (EX 3, 4). The Employer also submitted a chest X-ray interpretation, pulmonary function test and arterial blood gas test as part of Dr. Goldstein's examination; his examination also included an EKG (EX 4).

Dr. Jan Westerman performed the OWCP-sponsored evaluation, which included a chest X-ray interpretation, pulmonary function test, arterial blood gas test, and EKG (DX 9). These items will be discussed in greater detail below.

C. Entitlement

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. § 718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

As stated above, this proceeding is a request for modification of a subsequent claim. § 725.310. The amended regulations at § 725.310(c) provide that "[i]n any case forwarded for hearing, the administrative law judge assigned to hear such case shall consider whether any additional evidence submitted by the parties demonstrates a change in condition and, regardless of whether the parties have submitted new evidence, whether the evidence of record demonstrates a mistake in a determination of fact."

In determining whether a "change in conditions" is established, the fact-finder must conduct an assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to

determine if the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated against the claimant. Kingery v. Hunt Branch Coal Co., 19 B.L.R. 1-6 (1994). Even if a "change in conditions" is not established, evidence in the entire claim file must be considered to determine whether a "mistake in a determination of fact" was made. This is required even where no specific mistake of fact has been alleged. Kingery, supra. Moreover, a mistake of fact may be "demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." Zurat v. Director, OWCP, No. 98-1075 BLA (BRB: May 4, 1999).[3]

Further, specific limitations govern the submission of evidence on modification. Upon a request for modification, the parties are entitled to submit the evidence permitted under § 725.414, as well as additional evidence permitted under § 725.310. The Benefits Review Board recently held that these two provisions "should be read together to establish combined evidentiary limits on modification, to allow a party to submit for the first time in a modification proceeding all of the evidence permitted by each regulation…. Consequently, 20 C.F.R. §§ 725.414 and 725.310(b) apply together in modification proceedings on a claim." Rose v. Buffalo Mining Co., No. 06-0207 BLA, at 6 (BRB: Jan. 31, 2007). Based on this precedent, I find that neither party has exceeded the evidentiary limitations of § 725.414 in this matter.

a. District Director's Decision and Order

On June 7, 2004, the District Director issued its Proposed Decision and Order denying benefits, after it found that the Claimant did not meet any of the elements of entitlement (DX 15).

During its review, the District Director examined only the OWCP evaluation of Dr. Westerman, which included a chest X-ray interpretation, a pulmonary function study, an arterial blood gas study, and a physical examination. The District Director found the X-ray evidence negative, and the pulmonary function study and arterial blood gas study both non-qualifying. Further, after reviewing Dr. Westerman's report, the District Director found that pneumoconiosis was not diagnosed, and that a totally disabling pulmonary or respiratory condition also was not diagnosed.

Upon review of the District Director's decision, I find no evidence of a mistake in determination of fact. Therefore, I will examine the new evidence submitted by the Employer to determine whether there has been a change in the Claimant's condition, or whether the new or cumulative evidence establishes that a mistake in determination of fact has previously been made.

[3] The Employer never alleged any specific mistake of fact by ALJ Tierney. In its request for reconsideration, the Employer asserted that Dr. Rosenberg attributed the Claimant's disability to his smoking history.

1. Elements of Entitlement:

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, § 718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

(1) X-ray evidence: § 718.202(a)(1).
(2) Biopsy or autopsy evidence: § 718.202(a)(2).
(3) Regulatory presumptions: § 718.202(a)(3).[4]
(4) Physician opinion based upon objective medical evidence: § 718.202(a)(4).

1) X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

[4] These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§ 718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§ 718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§ 718.306).

The current record contains the following chest X-ray evidence:

Date of X-Ray	Date Read	Ex. No.	Physician	Radiological Credentials[5]	Interpretation
12/16/2003	12/16/2003	DX 9	Westerman	None	Negative
12/16/2003	04/06/2005	EX 1	Wiot	BCR, B reader	Negative
05/11/2005	05/11/2005	EX 4	Goldstein	B reader	Negative
05/11/2005	10/27/2005	EX 5	Wiot	BCR, B reader	Negative

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

Where two or more X-ray reports conflict, consideration shall be given to the radiological credentials of the physicians interpreting the X-rays. § 718.202(a)(1). It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 537 (1983). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

As listed above, the record contains two X-rays, both of which were interpreted twice. All four X-ray interpretations were negative for pneumoconiosis. Therefore, I find that the Claimant has not established pneumoconiosis by means of X-ray.

[5] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. § 37.51 for a general description of the B reader program.

2) Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is not available here, as the current record contains no such evidence.

3) Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions applies in this case, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

4) Physician Opinion

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. As set forth above, "legal" pneumoconiosis is defined as any chronic dust disease arising out of coal mine employment. Therefore, a physician opinion may be expected to address clinical pneumoconiosis or legal pneumoconiosis, or both.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following medical opinions:

Dr. Jan Westerman (DX 9)

Dr. Westerman examined the Claimant in December 2003, and wrote a medical report. His examination included a chest x-ray, pulmonary function test, arterial blood gas test; he also took a medical and work history. Dr. Westerman is Board certified in internal medicine, with subspecialties in critical care and pulmonary disease.

Concerning the Claimant's work history, Dr. Westerman noted that the Claimant is a retired coal miner, and that he worked underground from 1974 through 2001. Dr. Westerman also noted that the Claimant had a smoking history that began in 1968, and although he has stopped smoking multiple times, at the time of his evaluation, he was smoking one pack per day. Dr. Westerman wrote that, after accounting for the time that the Claimant quit smoking, he has a smoking history totaling 20 years.

Concerning the Claimant's symptoms, Dr. Westerman recorded that the Claimant reported the following: yellow sputum, nightly wheezing, dyspnea on exertion, daily cough, chest pain on exertion, 2 pillow orthopnea, and paroxysmal nocturnal dyspnea. In addition, the report noted that the Claimant reported he is short of breath on incline, and that he "can walk fairly good distance if he walks at a regular pace," but that he has to rest after going up a flight of stairs.

Upon physical examination of the Claimant, Dr. Westerman stated the following concerning the Claimant's lungs: "Clear, excellent air flow; no wheeze, ronchi (sic) or rales." Concerning the Claimant's extremities, the report states "No clubbing, cyanosis, or edema." Dr. Westerman made the following cardiopulmonary diagnoses: chronic bronchitis and mild obstructive lung disease. The etiologies of these diagnoses were listed as occupational exposure and tobacco abuse. Dr. Westerman also diagnosed the Claimant with a non-cardiopulmonary condition, specifically HLP [hyperlipidemia].

Finally, Dr. Westerman stated his overall impression as follows:

> Dyspnea is out of proportion to resting physiology. He does have mild obstruction with chronic bronchitic symptoms. His bronchitis may be related to exposure to dust and irritants in the coalmines (occupational and industrial bronchitis) as well as ongoing tobacco abuse. He may have a dynamic component and/or bronchospastic disease causing his extreme exertion dyspnea. Further evaluation with exercise testing and/or methacholine challenge may be warranted. Consideration of bronchodilator therapy is certainly indicated….

Dr. Allan Goldstein (EX 3, 4)

Dr. Goldstein examined the Claimant in May 2005, and wrote a medical report with his evaluation and conclusions. His examination included a chest x-ray, pulmonary function test, arterial blood gas test; he also took a medical and work history. Dr. Goldstein is Board certified in internal medicine with a subspecialty in pulmonary disease; he is also a certified B reader.

Concerning the Claimant's work history, Dr. Goldstein wrote that the Claimant reported that he worked in the "underground coal mining industry in 1974 and worked until 2001," and that "[h]e worked underground all of the time that he was in the mines." Dr. Goldstein also discussed other employment, such as the Claimant's work for a shirt company, and also his task of hauling glue for use in the mines.

Upon physical examination of the Claimant, Dr. Goldstein found that the Claimant's chest was "[c]lear to percussion and auscultation;" he also found "[n]o cyanosis, clubbing or edema." Dr. Goldstein recorded the following concerning the Claimant's reported relevant symptoms:

> He has had shortness of breath for about ten years. He noticed it initially while running and doing exercise or walking up a hill. It has been slowly but steadily progressive in the last ten years. He has had a cough "now and then". (sic) It occurs mainly in the morning when he gets up and is associated with sputum that at times is discolored. This began about 1998. He gets wheezing if he walks "a long distance" or does physical work. He also will get a feeling of faintness and weakness if he works hard or walks a long distance…. He did not notice any difference in his breathing when he was off work. His breathing did not suddenly worsen at any time while he was at work and he does not describe any acute symptoms related to being exposed to the glue that he hauled.

Dr. Goldstein summarized his conclusions as follows:

> [The Claimant] has worked in the underground coal mining industry for approximately twenty-seven years before he retired in 2001. He was exposed to coal dust, rock dust and diesel fumes. He apparently also hauled glue that was used to stabilize the mine roof. He has had shortness of breath that has been slowly progressive over the last ten years. He has had a cough "now and then" since 1998 and has had a wheeze related to "walking long distances" or doing physical work. He has no history of any heart disease. He has no history of acute shortness of breath while at work or any change in his symptoms at work or away from work. His smoking history is noted. His pulmonary functions suggest a mild airways obstructive defect. His chest x-ray is normal as are his pulmonary functions and arterial blood gases. It is my impression that this gentleman has shortness of breath, cough and wheezing secondary to smoking. He does not have any evidence of occupational pneumoconiosis and he does not have a history that would be consistent with respiratory illness related to exposure to glue.

Discussion

I find that Dr. Westerman was of the opinion that the Claimant had a mild obstruction with chronic bronchitis. Concerning the cause of those ailments, Dr. Westerman stated that these ailments "may be related to" 1) "exposure to dust and irritants in the coal mines," and 2) "ongoing tobacco abuse." Dr. Westerman did not explain the basis for his opinion on these etiologies, and he did not explain why he could not state his position more clearly and unequivocally. Therefore, I find his opinion not well reasoned. Because I find his opinion equivocal and not well reasoned, I give it little weight.

I find that Dr. Goldstein was of the opinion that the Claimant had a "mild airways obstructive defect," "shortness of breath, cough and wheezing," which were "secondary to smoking." While he stated his opinion on the etiology of the Claimant's ailment, Dr. Goldstein did not explain the basis for his opinion that the ailment was due to smoking. He did not explain

how or why he ruled out other possible causes, particularly the Claimant's coal dust exposure. Because I find that his opinion was not adequately reasoned, I give it little weight.

After considering the opinions of Dr. Westerman and Dr. Goldstein, I find that the Claimant has not established that he has either clinical or legal pneumoconiosis based on physician opinion.

Therefore, based on the foregoing, I find that the Claimant has not established, by a preponderance of the evidence, that he has either clinical or legal pneumoconiosis.

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b). In this case, the record establishes that the Claimant has at least 27 years of coal mine employment. Therefore, he is entitled to the rebuttable presumption. However, as set forth above, I find that the Claimant has failed to establish that he has pneumoconiosis. Consequently, he is unable to benefit from this presumption.

c. Whether the Claimant is Totally Disabled

The Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment . . . requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. § 718.204(a). See also Beatty v. Danri Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

1) Pulmonary Function Tests

A Claimant may establish total disability based upon pulmonary function tests. In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies

must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [FEV_1] test and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the FEV_1 divided by the FVC that is less than or equal to 55%. § 718.204(b)(2)(i). "Qualifying values" for the FEV_1, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The record contains the following pulmonary function test results:

Date of Test	Physician	Height	FEV_1	FVC	MVV	FEV_1/FVC ratio	Valid ?
12/16/2003	Westerman	70 in.	2.96	4.49	121.93	66	Yes
05/11/2005	Goldstein	68 in.	2.87/2.50*	4.14/4.36*	96/90*	69/57*	Unclear[6]

*The second set of numbers represents results after bronchodilator.

The Claimant was born in July of 1946, so he was 57 years old at the time of the first test, and 58 years old at the time of the second test. His height was listed at 70 inches, and 68 inches; I find that he is at least 68 inches tall. For a 57 year old male, who is 67.7 inches tall, the qualifying FEV_1 value is 1.92. For a 58 year old male, who is 67.7 inches tall, the qualifying FEV_1 value is 1.91. None of the pulmonary function studies produced qualifying results. Therefore, I find that the Claimant is unable to establish total disability under this provision.

2) Arterial Blood Gas Tests

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO_2] and percentage of oxygen [PO_2], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and PCO_2 level, a qualifying value must be less than or equivalent to the PO_2 listed in the table.

The record contains the following arterial blood gas test results:

Date of Test	Physician	PCO_2	PO_2	PCO_2 (post-exercise)	PO_2 (post-exercise)	Altitude
12/16/2003	Westerman	38.6	89.5	41.5	86	0-2999 ft
05/11/2005	Goldstein	36	89	N/A*	N/A	Not listed[7]

* Post-exercise trials not performed.

For a PCO_2 value of 36, at an altitude of 2999 feet or less, the qualifying PO_2 value must be equal to or less than 64. For a PCO_2 value between 38 and 39, at an altitude of 2999 feet or

[6] The original tracing of flow-volume loops is not in the record. It is unclear, from the copy in the record, whether all flow volume loops are complete. See Appendix B to Part 718.
[7] Per 29 C.F.R. § 18.201, judicial notice may be taken of adjudicative facts. The highest point in Alabama is 2,407 feet. See http://geology.com/states/alabama.shtml.

less, the qualifying PO_2 value must be equal to or less than 62. For a PCO_2 between 40 and 49, at an altitude of 2999 feet or less, the qualifying PO_2 value must be equal to or less than 60.

None of the arterial blood gas studies produced qualifying results. Therefore, I find that the Claimant is unable to establish total disability under this provision.

3) Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). As discussed above, I have not found that the Claimant had established that he has pneumoconiosis. In addition, there is no evidence of cor pulmonale with right-sided congestive heart failure. Accordingly, I find that the Claimant has not established total disability under this provision.

4) Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989). A physician's opinion must demonstrate an adequate understanding of the exertional requirements of the Claimant's coal mine employment. Brigance v. Peabody Coal Co., B.R.B. No. 05-0722 B.L.A. (June 29, 2006)(en banc).

Dr. Jan Westerman (DX 9)

Concerning respiratory or pulmonary disability, Dr. Westerman opined that the Claimant had 25% impairment due to "chronic bronchitis, distinct." He stated that the chronic bronchitis was caused by occupational exposure and tobacco abuse.[8]

Dr. Allan Goldstein (EX 3, 4)

While Dr. Goldstein discussed the Claimant's symptoms, his respiratory condition, and whether the Claimant had pneumoconiosis, Dr. Goldstein did not address the existence and extent of a respiratory or pulmonary disability.

[8] Dr. Westerman also diagnosed the Claimant with "HLP" [hyperlipidemia], as a disabling non-respiratory condition. Dr. Westerman did not describe the degree of the impairment caused by the hyperlipidemia.

Discussion

Although there are two physician opinions in the record, only Dr. Westerman opined on the issue of disability. Dr. Westerman found that the Claimant was 25% disabled by a chronic respiratory or pulmonary disease. However, Dr. Westerman did not explain how he arrived at this exact percentage, nor did he relate it to particular knowledge of the exertional requirements of the Claimant's last coal mine job of at least one year duration. Therefore, I find that his opinion is not well reasoned, and I give it little weight.

In sum, the record contains one opinion on the matter of disability, which I found was not well reasoned. In addition, I note that no physician of record opined that the Claimant is totally disabled due to a respiratory or pulmonary impairment. Therefore, after considering the physician opinion evidence, I find that the Claimant has not established that he has a respiratory or pulmonary impairment based on physician opinion.

Based on the foregoing, including the entirely non-qualifying pulmonary function tests and arterial blood gas tests, I find that the Claimant has not established, by a preponderance of the evidence, that he is totally disabled due to a respiratory or pulmonary condition.

d. Whether the Claimant's Disability is Due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. § 718.204(c); Lollar v. Alabama By-Products Corp., 893 F.2d 1258 (11th Cir. 1990). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. In general, the fact that an individual suffers or suffered from a totally disabling respiratory or pulmonary impairment is not, in itself, sufficient to establish that the impairment is or was due to pneumoconiosis. § 718.204(c)(2). A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c).

As discussed above, I found that the Claimant was unable to establish that he has pneumoconiosis, and he was unable to establish total disability due to a pulmonary or respiratory impairment. Therefore, I find that he is unable to establish this final element of entitlement, specifically, that he is totally disabled due to pneumoconiosis.

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established his entitlement to benefits under the Act. None of the elements of entitlement have been met, nor has a change in condition or mistake in determination of fact been established. § 725.310.

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

The Claimant's Claim for benefits under the Act is DENIED.

A

Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).